DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G148	A. BUILDING _____ B. WING _____	03/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 03	1814 BUNKER HILL ROAD, NE WASHINGTON, DC 20017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from 3/30/2010, through 3/31/2010. The survey was completed utilizing the fundamental survey process. A random sampling of three clients was selected from a residential population of three females and two males with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at two day programs, as well as a review of the client and administrative records, including the incident reports.	W 000		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on staff interview, and record review, the facility failed to establish a system that would ensure clients, family members or guardians were informed of the risks and benefits of clients restrictive measures, for one of three clients in the sample. (Client #1) The findings include: The facility failed to ensure that informed consent was obtained from Client #1's guardian prior to the administration of her psychotropic	W 124	Received 4/30/10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Martha Flowers, Vice President — TITLE — (X6) DATE: 4/30/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 124	Continued From page 1 medications as evidenced below. During the entrance conference on March 30, 2010, at approximately 10:30 a.m., the registered nurse (RN) and the qualified mental retardation professional (QMRP) indicated that Client #1 had a behavior support plan (BSP) to address her maladaptive behaviors, and received psychotropic medications to address her maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services. The statements were verified on March 30, 2010, at 6:55 p.m., through review of Client #1's psychological assessment dated January 19, 2010, and BSP dated February 2, 2010. According to the assessment, Client #1 "does not evidence the capacity to make independent decisions on her behalf or provide meaningful input into decisions regarding her habilitation planning, placement, financial, treatment, or medical matters. On March 31, 2010, at 8:55 a.m., review of the physician order dated March 1, 2010, revealed Client #1 was prescribed Buspar for psychotropic behaviors and Risperdal for intermittent explosive disorder. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to the administration of the psychotropic medication. 2. The facility failed to ensure that informed consent was obtained from Client #1's guardian	W 124	**W 124. 1; 2.** Informed consent for administration of Client # 1's Psychotropic Medications and implementation of her BSP have been obtained from her surrogate decision maker (Mother). In the future, the QMRP shall ensure that informed consents are signed prior to administration of Psychotropic medications and implementation of BSP.	**4/10/10**

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W 124	Continued From page 2 prior to the implementation of her Behavior Support Plan (BSP). Interview with the Registered Nurse (RN) and the QMRP on March 30, 2010, at approximately 10:30 a.m., during the entrance conference revealed that Client #1 had a Behavior Support Plan (BSP) to address her maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services. The statement was verified on March 30, 2010, at 6:55 p.m., through review of Client #1's psychological assessment dated January 19, 2010. According to the assessment, Client #1 "does not evidence the capacity to make independent decisions on her behalf or provide meaningful input into decisions regarding her habilitation planning, placement, financial, treatment, or medical matters. Record review on March 30, 2010, at 6:55 p.m., revealed the Behavior Support Plan (BSP) dated February 2, 2010, was implemented to address her maladaptive behaviors. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to implementing Client # 1's BSP.	W 124		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.	W 130		

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W 130	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure privacy during personal needs, for one of the three clients in the sample. (Client #2) The finding includes: On March 31, 2010, at 4:14 p.m., Client #2 was observed sitting on the toilet in the bathroom with the door open. During this time, her direct support staff was observed standing in the same bathroom. Seconds later, the licensed practical nurse (LPN) was observed leaving the bathroom, however, she did not close the door completely. When interviewed on the same day at approximately 7:00 p.m., the LPN acknowledged that Client #2 was not provided privacy while using the bathroom. At the time of the survey, there was no evidence that staff ensured privacy during Client #2's personal care.	W 130	W 130 Staff have been trained on issues pertaining to right, privacy, dignity and respect. The Facility's House Manager shall on a daily basis (5 days a week, Monday through Friday) ensure staff adhere to the specifications of the in-service.	4/29/10
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients had clothing that were appropriate, for one of three clients in the sample. (Client #1)	W 137		

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W 137	Continued From page 4 The finding includes: Observation conducted at Client #1's day program on March 30, 2010, 11:41 a.m., revealed Client #1 walking out her classroom wearing jeans that was too small. Further observation revealed the day program staff trying to pull the client's jeans over her hips. Interview with the day program staff on March 30, 2010, at 11:45 a.m., revealed the facility frequently sent Client #1 to the day program wearing clothes that were too small. The day program reportedly had conveyed its concern to the facility (dates unknown). Further observation on March 31, 2010, at 1:45 p.m., revealed clothes stored in Client #1's closet and dresser that were too small for her. Additional observation revealed seven out of nine supportive stockings had holes or were torn. Three out of ten underwear were stained, and three suits hanging in her closet were also stained. Interview with the qualified mental retardation professional on March 31, 2010, at approximately 3:00 p.m., confirmed the observations of the clothing in Client #1's dresser and closet, however stated that he was not aware of the day programs concerns. At the time of the survey, there was no evidence that the facility ensured that Client #1 wore appropriately fitting clothing, or that the client's clothing were maintained in good condition.	W 137	W 137 The house manager has requested funds from client # 1's community account so as to purchase new fittings clothes. In the mean time client # 1's closet has been reorganized whereby all tight clothes and ted hose with holes have been removed.	4/29/10 4/01/10
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS	W 154		

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W 154	Continued From page 5 The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate all incidents, for one of three clients in the sample. (Client #2) The finding includes: Review of the facility's unusual incident reports (UIR) and investigative reports on March 30, 2010, beginning at 8:55 a.m., revealed on January 31, 2010, staff heard a scream, then discovered a scratch on the right side of Client #2's eye brow. According to the investigation report, it appeared that Client #1 may have scratched Client #2. Observation of Client #1 at the day program on March 30, 2010, beginning at 11:41 a.m., revealed the client verbally communicating with the staff. On both March 30, 2010 and March 31, 2010, upon her return from the day program at approximately 4:00 p.m., and throughout the evening, the client was observed verbally communicating with group home staff. However, there was no evidence that the incident management coordinator (IMC) interviewed the client regarding the scratch on the right side of Client #2's eye brow. Interview with the Qualified Mental Retardation Professional (QMRP) on March 31, 2010, at approximately 6:45 p.m., confirmed Client #1 was not interviewed concerning Client #2's injury. There was no evidence that the IMC conducted	W 154	W 154 The IMC (Incident Management Coordinator) has been informed about the incompleteness of the incident investigation report. In the future the QMR shall review all investigations to ensure that the requirement of a complete investigation are adhere to and to ensure that documentary evidence is provided to support that the administration was informed of the recommendations of the investigation.	

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W 154	Continued From page 6 an thorough investigation to determine if Client #1 scratched Client #2.	W 154		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations to the administrator, designated representative or to other officials in accordance with State Law within five working days of the incident, for one of three clients in the sample. (Clients #2) The finding includes: Review of the facility's incident and investigative reports on March 30, 2010, beginning at 8:55 a.m., revealed the following incidents and investigative reports: a. On March 22, 2010, the registered nurse (RN) was notified that there was a reddened swollen area on the back of Client #2's upper right thigh that was warm and painful to touch. The RN instructed the staff to take the client to the emergency room. According to the investigation, the client was diagnosed with an abscess and prescribed medication upon discharge. b. On January 31, 2010, staff heard a scream then discovered a scratch on the right side of Client #2's eye brow. According to the investigation report, it appeared that Client #1	W 156	**W 156. a, b.** Cross reference to **W 154.**	

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W 156	Continued From page 7 may have scratched Client #2., Further review of the investigative report revealed that Client #2 and Client #1 no longer share the same bedroom. An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on March 31, 2010, at approximately 6:45 p.m., to ascertain information regarding the facility's incident management system. According to the QMRP, all investigative results were completed by the Incident Management Coordinator and reported to the administrator. On March 30, 2010, at approximately 9:45 a.m., review of the investigative reports revealed that there was no documented evidence that the administrator had been notified of the results of the aforementioned investigations. At the time of the survey, the facility failed to provide evidence that verified the administrator was notified of the results of the investigative reports within five working days as required.	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated and monitored services, for three of the five clients residing in the facility. (Clients #1, #2 and #4)	W 159		

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W 159	Continued From page 8 The findings include: 1. The QMRP failed to ensure that each staff were effectively trained to implement the therapeutic diets of Clients #1, #2 and #4. [See W192] 2. The QMRP failed to ensure each staff was trained to implement Client #2's behavior plan as written. [See W191] 3. The QMRP failed to ensure data relative to the accomplishment of Client #2's behavioral and communication objectives were consistently maintained. [See W252]	W 159	W 159. 1. Refer to W 192 W 159. 2. See W 191 W 159. 3. See W 252	
W 191	483.430(e)(2) STAFF TRAINING PROGRAM View in-service training as a dynamic growth process. It is predicated on the view that all levels of staff can share competencies which enable the individual to benefit from the consistent, wide-spread application of the interventions required by the individual's particular needs. In the final analysis, the adequacy of the in-service training program is measured in the demonstrated competencies of all levels of staff relevant to the individual's unique needs as well as in terms of the "affective" characteristics of the caregivers and the personal quality of their relationships with the individuals. Observe the staff's knowledge by observing the outcomes of good transdisciplinary staff development (i.e., in the principles of active treatment) in such recommended competencies as: · Respect, dignity, and positive regard for individuals (e.g., how staff refers to individuals,	W 191		

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W 191	Continued From page 9 refer to W150); Use of behavioral principles in training interactions between staff and individuals; · Use of developmental programming principles and techniques, e.g., functional training techniques, task analysis, and effective data keeping procedures; · Use of accurate procedures regarding abuse detection and prevention, restraints, medications, individual safety, emergencies, etc.; · Use of adaptive mobility and augmentative communication devices and systems to help individuals achieve independence in basic self-help skills; and · Use of positive behavior intervention programming. §483.430(e)(2) Probes Does the staff training program reflect the basic needs of the individuals served within the program? Does observation of staff interactions with individuals reveal that staff know how to alter their own behaviors to match needs and learning style of individuals served? For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs.	W 191		

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W 191	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each staff was provided training to effectively address the behavioral needs of one of three clients in the sample. (Client #2) The findings include: The facility failed to ensure training on strategies identified in Client #2's behavior support plan were consistently implemented, as evidenced below: 1. Observation on March 30, 2010, at 7:30 a.m., revealed Client #2 sitting in dining armchair with her legs crossed in the seat of the chair. During this time, the client had her eyes closed, made no sounds and appeared to be sleeping. She remained in this position until 8:20 a.m., At that time, she opened her eyes, raised her shirt, and scratched her stomach. At 8:25 a.m., a staff escorted her out of the living room, then back to the living room, where she sat to have her shoes put on by staff. The client was first observed wearing a helmet at 8:33 a.m., when a staff put it on her head. The client yawned, then began to repeatedly and slowly lean forward then back to an upright position as she sat in the dining armchair. Interview with the group home staff on March 31, 2010, at 3:35 p.m., revealed Client #2 sometimes removes her own helmet and places it beside her when she is sitting. Staff further indicated that the client should wear the helmet to prevent possible SIB (head-banging). On March 31, 2010, at approximately 3:35 p.m.,	W 191		

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W 191	Continued From page 11 the review of Client #2's behavior support plan dated December 1, 2009, revealed the client's targeted behaviors include self-injurious behaviors (head banging). The identified strategy in the BSP for SIB stated, "[Client] should wear her helmet during waking hours to prevent injury to her head, except during meals." (It was also noted that the physician's orders for March 1, 2010, stated, "helmet on in the morning and off in the evenings to prevent head injury.") At the time of the survey, the was no evidence staff demonstrated competency to implement strategies identifed in Client #2's BSP. 2. Observation on March 30, 2010, at 5:12 p.m., revealed the Client #2 seated a the dining table with her housemates and direct support staff. Further observation revealed the direct support staff drawing hand over hand with Client #2. At 5:15 p.m., the client screamed, spit, pulled the staff's shirt and pushed away everything in front of her. One minute later, the house manager offered the client a guitar. The client began to scream, pulled the direct support staff's arm, then began to scratch her own arm. The house manager asked her if she was "ok", then she gave the client a high five. At 5:19 p.m., the direct support staff placed beads in front of the client. The client pushed the beads away and screamed. At 5:23 p.m., the direct support staff asked the client to play the tambourine. The client screamed and shook her head. At 5:24 p.m., the client began to scream when the direct support staff attempted to engage her with blocks. At 5:25 p.m., another staff held different scents in front of her nose. At 5:26 p.m., the direct support staff asked her to color, however she began to scream again. At 5:28 p.m., another staff placed	W 191	**W 191. 1; 2 a, b, c.** Staff will be retrained on the interventions specified in Client # 2's BSP. The QMRP and the House Manager shall on a weekly basis monitor staff implementation of BSP so as to ensure compliance.	**5/20/10**

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W 191	Continued From page 12 crayons in her hands and asked her to color. The client screamed and lift the table about an 1 1/2 from the floor then pushed the staff away. Interview with the Qualified Mental Retardation Professional (QMRP) on March 31, 2010, at approximately 7:00 p.m., revealed that all staff were trained on Client #2's BSP. Review of the staff in-service training records verified revealed Client #2's direct support staff were trained on December 1, 2009. Review of Client #2's BSP dated December 1, 2009, on March 31, 2010, at 4:25 p.m., revealed the client had maladaptive behaviors including self-injurious behaviors, aggressive behavior and exhibits episodes of crying and screaming. As a result, staff were required to proactively inform Client #2 five minutes ahead of time when a change of activity or location was going to occur to prevent agitation. Additionally, the plan documented that staff should encourage the client to "gesture pain, needs, and/or discomfort. " Further review of the BSP revealed the following consequences to target behaviors: a. Verbally direct the client to stop the behavior; b. Communicate with her to determine if she may be experiencing discomfort or otherwise; (for physical discomfort apply lotion and/or moisturizer) c. After she has calmed down , she should be gradually redirected to a task that she is able to successfully do, as a means of bolstering her seff-esteem and to prevent an immediate recurrence of aggression or self-injurious behaviors.	W 191		

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	09G148	A. BUILDING _____ B. WING _____	03/31/2010

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W 191	Continued From page 13 At the time of the survey, there was no evidence that the facility ensured each staff was effectively trained to implement strategies to manage and document Client #2's targeted behavior of screaming.	W 191		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that all staff were effectively trained to address the health care needs of three of the five clients residing in the facility. [Clients #1, #2 and #4) The findings include: 1. The facility failed to ensure that each staff was trained to prepare Client #4's pureed diet in accordance with menu instructions, as evidenced below: On March 30, 2010, at 2:10 p.m., a staff was observed feeding Resident #4 pureed food from a large bowl. Further observation of the food revealed different types of food appeared to be mixed together, and that the individual foods could not be identified. Interview on March 30, 2010, at 2:23 p.m., with the staff who prepared Client #4's meal and fed it to him, revealed that the entire meal, including the dessert, had been pureed and blended together. The staff indicated that the meal was prepared in	W 192		

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W 192	Continued From page 14 accordance with the written instructions on the menu. Interview with the RN on March 31, 2010, at approximately 6:15 p.m. revealed the employee had previously worked at the group home. Further discussion with the RN revealed that the employee was presently providing temporary coverage at the group home and possibly had not been trained on the new menu procedures for preparing pureed food. Review of the lunch menu dated March 30, 2010, for Resident #4's Regular, Pureed Diet revealed the following instructions: Blend 1/2 avocado with 1 cup prepared Cream Soup; add 6 Ritz Crackers or 2- Tbsp Wheat Germ to thicken as needed. Blend 1/2 cup fortified Milk with 1/2 cup Ice Cream and 1/2 cup Canned Fruit. The review of the physician's orders dated March 1, 2010, on March 31, 2010, at 4:10 p.m. revealed Client #4 was prescribed a regular, pureed diet with 5 -6 cans of Ensure high Protein daily as tolerated and a high calorie lunch. At the time of the survey, there was no evidence that each staff had received training adequate to ensure Client #4 received his pureed diet prepared in accordance with the nutritionist's instructions. 2. The facility failed to ensure Client #2's pureed diet was prepared in the correct texture as evidenced below:	W 192	**W 192. 1 & 2.** The Nutritionist will retrain staff on diet texture (to ensure that food is consistently provided in prescribed texture) and mealtime protocol for clients # 4 and #2. The House Manager shall on a daily basis (five days a week, Monday through Friday) monitor staff to ensure diet texture and mealtime protocol are adhered to.	5/20/10

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W 192	Continued From page 15 On March 30, 2010, at approximately 6:15 p.m., Client #2 was presented pureed food in a 3 section plate for dinner. The food appeared flat on the plate and fell from the spoon when it was tilted. At 6:30 p.m., approximately 80% of the food remained on the client's plate. The client became agitated and her plate was removed from the dining table to the kitchen. She was then offered a choice of several flavors of jello as a dessert. On March 30, 2010, at 6:35 p.m., interview with the staff who prepared the food indicated that broth was added to the food during the pureeing process to make the food into a creamier consistency. Further discussion with the staff indicated that the use of the broth in preparing the pureed food had been approved. The review of the physician's orders dated March 1, 2010, on March 31, 2010 at 9:36 a.m., revealed Client #2 was prescribed a low fat, low cholesterol, pureed diet. At the time of the survey, there was no evidence that each staff had received training to ensure that Client #2's food was consistently provided in the prescribed texture. 3. The facility failed to ensure staff demonstrated competency in implementing client's weight loss plan, for Client #1 as evidenced below: On March 30, 2010, at 4:52 p.m., the direct support staff was observed to offer Client #1 a choice between two different types of crackers. The client chose Cheese It crackers and juice for her snack. After the client finished eating her crackers, she asked for more and instead was given sliced apples.	W 192		

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W 192	Continued From page 16 Review of Client #1's record on March 31, 2010, at 4:30 p.m., revealed a weight loss plan dated August 15, 2009. According to the plan, Client #1's snack should provide 35 calories or less per serving. The plan also states that the client should receive one item from the following list: - 1/2 cup sugar free jello - 1/2 cup sugar free pudding - 8 baby carrots with 1/4 cup fat free salad dressing - 4 celery sticks with 2 tablespoons fat free salad dressing - 1/2 sliced cucumber - 4 raw broccoli florets with 2 tablespoons fat free salad dressing - 1 cup salad with 2 tablespoons fat free salad dressing - 1 rice cake - 1/2 cup of any cooked vegetables Interview with the direct support staff on March 31, 2010, at 6:35 p.m., revealed that she offers Client #1 crackers, oreo cookies and potato chips for snacks. On March 31, 2010, beginning at approximately 11:00 a.m., review of staff in-service training records revealed that the staff who was observed assisting Client #1 during snack had not received training on the client's weight loss plan.	W 192	**W 192. 3** The Nutritionist will train staff on Client # 1's weight loss plan. The Facility's House Manager shall on a daily basis (5 days a week, Monday through Friday) ensure not only the staff observed assisting Client # 1 during snack but all staff working with Client # 1 adhere to the list of diet types prepared by the Nutritionist to be given to Client # 1 in the instance of a choice to promote Client #1's weight loss program.	5/20/10
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.	W 252		

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W 252	Continued From page 17 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure consistent documentation of progress on the Individual Program Plan (IPP) objective, for one of three clients in the sample. (Client #2) The finding includes: The facility failed to provide evidence that data was consistently maintained on Client #2's training objective designed to improve her communication, as evidenced below: Observation of Client #2 on March 30, 2010, at approximately 3:40 p.m., revealed a staff asking her name and where she lived. The client was not observed to respond verbally; however, the staff stated the client's full name and complete address to her. The staff showed the surveyor a small picture frame - like device, which was approximately 2.5 inches square, and contained a picture of Client #2. When the button on the device was pushed, it activated an internal mechanism which caused the device to state the client's full name and address. Interview with staff on March 30, 2010, at 8:12 a.m., revealed Client #2 was non-verbal, however was able to understand some commands. Continued interview with staff on March 31, 2010. at 11:47 a.m., revealed the voice output device was used to help Client #2 become familiar with her personal information (name and address). Staff further stated that although the client was not able to talk, with hand over hand assistance she was able to press the button to activate the	W 252		

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W 252	Continued From page 18 voice in the device. On March 31, 2010, at 2:20 p.m., a staff stated, "We use it (voice output device) after she comes home. It says her name and where she lives. We write it down in her book." On March 31, 2010, at approximately 12:10 p.m., the home manager and the qualified mental retardation professional (QMRP) were interviewed regarding Client #2's performance in the communication objective using the voice output device. The discussion revealed data collected should be maintained in the training book. Continued interview with the QMRP, however verified that the monthly data collection forms were currently not available. Record review on March 31, 2010, at 1:17 p.m., revealed the individual support plan (ISP) was amended on July 22, 2009, to include an objective using a "Go Talk, etc. low tech device to improve Client #2's communication. Further record review revealed a goal to improve the client's functional communication had been approved by the IDT on July 23, 2009. The objective stated, " Given physical assistance from staff, [Client] will utilize a low-tech device to respond to query for personal information on 60% trials recorded per month." Review the QMRP summaries revealed monitoring of the training objective after the ISP. Records to verify the data collection, however, were not available during the survey. At the time of the survey, however, there was no evidence the facility had ensured consistent data collection to facilitate accurate monitoring of Client #2's progress in the objective.	W 252	W 252 The data collection forms for Client #2's functional communication program have been put in her training book. The Facility's QMRP will on a monthly basis review training book to ensure program data are collected as specified.	4/01/10

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W 252	Continued From page 19 2. Cross-refer to W249.2. The facility failed to ensure Client's exhibited targeted behavior was accurately documented, as evidenced below. Review of Client #2's behavior support plan dated December 1, 2009, revealed interventions to address her targeted behaviors of "screaming, crying, Self injurious behaviors (SIB), and aggressive behavior. Instructions for documentation of the behaviors revealed staff should "Document on the ABC data collection form each time [Client] displays, (1) Self-injurious behaviors (wrist bitting, head banging, skin picking and scratching; (2) Physical aggression (pinching - hitting others); (3) Screaming/yelling/crying." Review of the ABC data collection on March 31, 2010, at 3:20 p.m., revealed one behavior was documented on March 30, 2010, for Client #2. Further review of the ABC data collection form revealed that staff documented that the client screamed and yelled from 6:00 p.m. to 6:15 p.m., while sitting in the living room. Staff noted that the consequence of the intervention was that the client stopped screaming. At the time of the survey, there was no evidence that the facility ensured documentation on the ABC data collection form each time the client displayed a targeted behavior.	W 252	W 252. 2. Cross-refer to W 249	
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	W 263		

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W 263	Continued From page 20 This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only after written consents had been obtained, for one of three clients in the sample. (Client #1) The findings include: Cross-refer to W124. The facility failed to ensure that written consent was obtained from Client #1's guardian prior to the administration of psychotropic medications and the implementation of a behavior support plan. On March 30, 2010, at approximately 10:30 a.m., the registered nurse (RN) and the qualified mental retardation professional (QMRP) indicated that Client #1 was prescribed psychotropic medications and had a behavior support plan to address her maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services. On March 31, 2010, at 8:55 a.m., review of the physician order dated March 1, 2010, revealed Client #1 was prescribed Buspar for psychotropic behaviors and Risperdal for intermittent explosive disorder. Record review on March 30, 2010, at 6:55 p.m., revealed Behavior Support Plan (BSP) dated February 2, 2010, was implemented to address her maladaptive behaviors. At the time of the survey, however, there was no evidence provided that the specially constituted committee had ensured written consent was obtained from the client and/or legally authorized representative prior to the administration of the	W 263	W 263 Cross-refer to W 124.	

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W 263	Continued From page 21 psychotropic medication and the implementation of the BSP.	W 263		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview, and the record review, the facility failed to ensure assistive devices were used as recommended by the interdisciplinary team for two of the five clients residing in the facility. (Clients #2 and #4) The findings include: 1. The facility failed to ensure Client #2 was taught to make informed choices concerning the use of her helmet, as evidenced below: Observation on March 30, 2010, at 7:30 a.m., revealed Client #2 sitting in dining armchair with her legs crossed in the seat of the chair. During this time, the client had her eyes closed, made no sounds and appeared to be sleeping. She remained in this position until 8:20 a.m., At that time, she opened her eyes, raised her shirt, and scratched her stomach. At 8:25 a.m., a staff escorted her out of the living room, then back to the living room, where she sat to have her shoes put on by staff. The client was first observed wearing a helmet at 8:33 a.m., when a staff put it on her head.	W 436		

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W 436	Continued From page 22 Interview with the group home staff on March 31, 2010, at 3:35 p.m., revealed Client #2 sometimes removes her own helmet and lays it beside her when she is sitting. Staff further indicated that the client should wear the helmet to prevent possible SIB (head-banging). On March 31, 2010, at approximately 3:35 p.m., the review of Client #2's physician's orders dated March 1, 2010 revealed, "helmet on in the morning and off in the evenings to prevent head injury." Client #2's behavior support plan (BSP) dated December 1, 2009, revealed... "[Client] should wear her helmet during waking hours to prevent injury to her head, except during meals." At the time of the survey, the was no evidence that the facility consistently encouraged Client #3 to wear her helmet as prescribed. 2. The facility failed to ensure Client #4 was provided a padded shower chair as prescribed, as evidenced below: Observation of the bathroom on the main level of the facility on March 31, 2010, at 1:58 p.m. revealed a shower chair with a seat constructed of a solid, rigid material. Further observation in the bathroom revealed a square vinyl covered pillow, which was approximately 12 inches x 12 inches x 2 inches deep. Interview with staff on March 31, 2010, at 2:01 p.m., revealed the aforementioned square pillow was positioned vertically at the back of the chair during showers. According to the staff, if padding was needed on the seat of the chair, towels were used.	W 436	**W 436, 1.** The Facility's QMRP will retrain on helmet usage by Client #2. House Manager shall on a daily basis (5 days a week, Monday through Friday) monitor staff to ensure compliance with helmet usage as specified in Client # 2's BSP and physician's orders. **W 436, 2.** An order will be placed for the specified shower chair (padded shower chair)	5/20/10 5/20/10

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W 436	Continued From page 23 On March 31, 2010, at 3:07 p.m., the review of Client #4's physician's orders for March 1, 2010 revealed an order, "March 10, 2008 - Padded shower chair". At the time of the survey, there was no evidence a padded shower chair was available for Client #4.	W 436		
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the texture of foods was provided as provided as prescribed for one of three clients in the sample. (Client #2) The finding includes: Cross Refer to W192.1. The facility failed to ensure Client #2's pureed diet was prepared in the correct texture.	W 474	W 474 Cross Refer to W 192. 1.	

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Health Regulation Administration

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I 000	INITIAL COMMENTS A re-licensure survey was conducted from March 30.2010, through March 31, 2010. A random sampling of three residents was selected from a residential population of three females and two males with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at two day program, as well as a review of the resident and administrative records, including the incident reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure the interior and exterior of the GHMRP were maintained in a safe, clean, orderly, attractive, and sanitary manner for five of five residents.(Residents #1, #2, #3, #4, and#5) The findings include: During the inspection of the environment on March 31, 2010, beginning at 11:30 a.m., the following concerns were identified: A. Exterior: 1. Mildew was observed on the railings of the wheelchair ramp located at the rear of the	I 090	**1090 A. 1.** Railings of Wheelchair ramp located at the rear of the GHMRP have been power washed.	4/01/10

Matt Thomas — Vice President — TITLE — (X6) DATE 4/30/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM 9RH311 If continuation sheet 1 of 15

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	HFD03-0070	A. BUILDING _____ B. WING _____	03/31/2010

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I 090	Continued From page 1 GHMRP. 2. There was an accumulation of trash near the wheelchair ramp located at the rear of the GHMRP. 3. Several loose boards were observed on the wheelchair ramp. The aforementioned observations were acknowledged by the House Manager Coordinator, who accompanied the surveyor during the inspection of the environment. B. Interior: On March 30, 2010 at 7:51 a.m., a staff was observed spraying the hardwood floor in the living room with an oil-based polish, and them buffing the area with a dust mop. The process rendered the floor slightly slippery. Observation of the hardwood floor in the bedroom of Resident #4 on March 31, 2010 at 2:10 p.m. revealed the hardwood floor was shining and slippery. Interview with the staff on March 30, 2010 on at 7:55 am., and on March 31, 2010 at 2:13 p.m. revealed an oil based spray polish was used to maintain the hardwood floor.	I 090	**1090 A. 2.** Trash accumulated near the wheelchair ramp located at the rear of the GHMRP has been removed. **1090 A. 3.** Loose boards observed on the wheelchair ramp have been nailed in place. Facility's QMRP and House Manager will do regular environmental checks to ensure the facility's environment is kept clean and safe. **1090 B.** The oil-based polish, "Orange glo for wood furniture" used on the hardwood floor in the living room during the survey has been changed to "pledge for wood".	3/31/10 3/31/10 4/28/10
I 108	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities. *This Statute is not met as evidenced by:*	I 108		

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I 108	Continued From page 2 Based on observation, interview and record review, the GHMRP failed to ensure that residents had clothing that was appropriate, for one of the three residents in the sample. (Resident #1) The finding includes: Observation conducted at Resident #1's day program on March 30, 2010, 11:41 a.m., revealed Resident #1 walking out her classroom wearing jeans that was too small. Further observation revealed the day program staff trying to pull the resident's jeans over her hips. Interview with the day program staff on March 30, 2010, at 11:45 a.m., revealed the facility frequently sent Resident #1 to the day program wearing clothes that were too small. The day program reportedly had conveyed its concern to the facility (dates unknown). Further observation on March 31, 2010, at 1:45 p.m., revealed clothes stored in Resident #1's closet and dresser that were too small for her. Additional observation revealed seven out of nine supportive stockings had holes or were torn. Three out of 10 underwear were stained, and three suits hanging in her closet were also stained. Interview with the qualified mental retardation professional on March 31, 2010 at approximately 3:00 p.m., confirmed the observations of the clothing in Resident #1's dresser and closet. At the time of the survey, there was no evidence that the facility ensured that Resident #1 wore appropriately fitting clothing, or that the resident's clothing were maintained in good condition.	I 108	**1108** The house manager has requested funds from client # 1's community account so as to purchase new fittings clothes. In the mean time client # 1's closet has been reorganized whereby all tight clothes and ted hose with holes have been removed.	**4/29/10** **4/01/10**

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I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the group home for the mentally retarded person's (GHMRP) failed to have an annual health screening for one of eleven consultants, as required by this section . The finding includes: The record review conducted on March 31, 2010, at approximately 2:00 p.m., revealed the health screening form for one of eleven consultants lacked the signature of the individual who performed the health screening. Interview with the house manager (HM) at approximately 2:05 p.m. verified that the aforementioned health screening form had not been signed.	I 206	1206 Wholistic Services Administration will obtain a signed Annual Health Screening Certificate from consultant in question. Wholistic Administration will review all Annual Health Screening Certificates in future so as to ensure compliance.	5/20/10
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure that all staff	I 222		

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I 222	Continued From page 4 received continuous, ongoing inservice to address the needs of three of the five residents in the GHMRP. (Residents #1, #2 and #4) The findings include: 1. The GHMRP failed to ensure that each staff was trained to prepare Resident #4's pureed diet in accordance with menu instructions, as evidenced below: On March 30, 2010, at 2:10 p.m., a staff was observed feeding Resident #4 pureed food from a large bowl. Further observation of the food revealed different types of food appeared to be mixed together, and that the individual foods could not be identified. Interview on March 30, 2010, at 2:23 p.m., with the staff who prepared Resident #4's meal and fed it to him, revealed that the entire meal, including the dessert, had been pureed and blended together. The staff indicated that the meal was prepared in accordance with the written instructions on the menu. Interview with the RN on March 31, 2010, at approximately 6:15 p.m. revealed the employee had previously worked at the group home. Further discussion with the RN revealed that the employee was presently providing temporary coverage at the group home and possibly had not been trained on the new menu procedures for preparing pureed food. Review of the lunch menu dated March 30, 2010, for Resident #4's Regular, Pureed Diet revealed the following instructions: Blend 1/2 avocado with 1 cup prepared Cream	I 222		

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I 222	Continued From page 5 Soup; add 6 Ritz Crackers or 2- Tbsp Wheat Germ to thicken as needed. Blend 1/2 cup fortified Milk with 1/2 cup Ice Cream and 1/2 cup Canned Fruit. The review of the physician's orders dated March 1, 2010, on March 31, 2010, at 4:10 p.m. revealed Resident #4 was prescribed a regular, pureed diet with 5 -6 cans of Ensure high Protein daily as tolerated and a high calorie lunch. At the time of the survey, there was no evidence that each staff had received training adequate to ensure Resident #4 received his pureed diet prepared in accordance with the nutritionist's instructions. 2. The GHMRP failed to ensure Resident #2's pureed diet was prepared in the correct texture as evidenced below: On March 30, 2010, at approximately 6:15 p.m., Resident #2 was presented pureed food in a 3 section plate for dinner. The food appeared flat on the plate and fell from the spoon when it was tilted. At 6:30 p.m., approximately 80% of the food remained on the resident's plate. The resident became agitated and her plate was removed from the dining table to the kitchen. She was then offered a choice of several flavors of jello as a dessert. On March 30, 2010, at 6:35 p.m., interview with the staff who prepared the food indicated that broth was added to the food during the pureeing process to make the food into a creamier consistency. Further discussion with the staff indicated that the use of the broth in preparing the pureed food had been approved.	I 222	1222. 1; 2. The Nutritionist will retrain staff on diet texture (to ensure that food is consistently provided in prescribed texture) and mealtime protocol for clients # 4 and #2. The Facility's House Manager will on a weekly basis (Monday through Friday) monitor staff to ensure diet texture and mealtime protocol are adhered to.	5/20/10

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I 222	Continued From page 6 The review of the physician's orders dated March 1, 2010, on March 31, 2010 at 9:36 a.m., revealed Resident #2 was prescribed a low fat, low cholesterol, pureed diet. At the time of the survey, there was no evidence that each staff had received training to ensure that Resident #2's food was consistently provided in the prescribed texture. 3. The GHMRP failed to ensure staff demonstrated competency in implementing Resident #1's weight loss plan, as evidenced below: On March 30, 2010, at 4:52 p.m., the direct support staff was observed to offer Resident #1 a choice between two different types of crackers. The resident chose Cheese It crackers and juice for her snack. After the resident finished eating her crackers, she asked for more and instead was given sliced apples. Review of Resident #1's record on March 31, 2010, at 4:30 p.m., revealed a weight loss plan dated August 15, 2009. According to the plan, Resident #1's snack should provide 35 calories or less per serving. The plan also states that the resident should receive one item from the following list: - 1/2 cup sugar free jello - 1/2 cup sugar free pudding - 8 baby carrots with 1/4 cup fat free salad dressing - 4 celery sticks with 2 tablespoons fat free salad dressing - 1/2 sliced cucumber - 4 raw broccoli florets with 2 tablespoons fat free	I 222	1222. 3. The Nutritionist will train staff on Client # 1's weight loss plan. The Facility's House Manager shall on a daily basis (5 days a week, Monday through Friday) ensure not only the staff observed assisting Client # 1 during snack but all staff working with Client # 1 are adhering to the list of diet types prepared by the Nutritionist to be given to Client # 1 in the instance of a choice to promote Client #1's weight loss program.	5/20/10

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I 222	Continued From page 7 salad dressing - 1 cup salad with 2 tablespoons fat free salad dressing - 1 rice cake - 1/2 cup of any cooked vegetables Interview with the direct support staff on March 31, 2010, at 6:35 p.m., revealed that she offers Resident #1 crackers, oreo cookies and potato chips for snacks. On March 31, 2010, beginning at approximately 11:00 a.m., review of staff in-service training records revealed that the staff who was observed assisting Resident #1 during snack had not received training on the resident's weight loss plan. 4. The GHMRP failed to ensure training on strategies identified in Resident #2's behavior support plan were consistently implemented, as evidenced below: a. Observation on March 30, 2010, at 7:30 a.m., revealed Resident #2 sitting in dining armchair with her legs crossed in the seat of the chair. During this time, the resident had her eyes closed, made no sounds and appeared to be sleeping. She remained in this position until 8:20 a.m., At that time, she opened her eyes, raised her shirt, and scratched her stomach. At 8:25 a.m., a staff escorted her out of the living room, then back to the living room, where she sat to have her shoes put on by staff. The resident was first observed wearing a helmet at 8:33 a.m., when a staff put it on her head. The resident yawned, then began to repeatedly and slowly lean forward then back to an upright position as she sat in the dining armchair.	I 222		

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I 222	Continued From page 8 Interview with the group home staff on March 31, 2010, at 3:35 p.m., revealed Resident #2 sometimes removes her own helmet and places it beside her when she is sitting. Staff further indicated that the resident should wear the helmet to prevent possible SIB (head-banging). On March 31, 2010, at approximately 3:35 p.m., the review of Resident #2's behavior support plan dated December 1, 2009, revealed the resident's targeted behaviors include self-injurious behaviors (head banging). The identified strategy in the BSP for SIB stated, "[Resident] should wear her helmet during waking hours to prevent injury to her head, except during meals." (It was also noted that the physician's orders for March 1, 2010, stated, "helmet on in the morning and off in the evenings to prevent head injury.") At the time of the survey, the was no evidence staff demonstrated competency to implement strategies identified in Resident #2's BSP. b. Observation on March 30, 2010, at 5:12 p.m., revealed the Resident #2 seated a the dining table with her housemates and direct support staff. Further observation revealed the direct support staff drawing hand over hand with Resident #2. At 5:15 p.m., the resident screamed, spit, pulled the staff's shirt and pushed away everything in front of her. One minute later, the house manager offered the resident a guitar. The resident began to scream, pulled the direct support staff's arm, then began to scratch her own arm. The house manager asked her if she was "ok", then she gave the resident a high five. At 5:19 p.m., the direct support staff placed beads in front of the resident. The resident pushed the beads away and screamed. At 5:23 p.m., the direct support staff asked the resident to	I 222	**1222. 4 a, b.** Staff will be retrained on the interventions specified in Client # 2's BSP. The QMRP and the House Manager will on a weekly basis monitor staff implementation of BSP so as to ensure compliance.	5/20/10

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I 222	Continued From page 9 play the tambourine. The resident screamed and shook her head. At 5:24 p.m., the resident began to scream when the direct support staff attempted to engage her with blocks. At 5:25 p.m., another staff held different scents in front of her nose. At 5:26 p.m., the direct support staff asked her to color, however she began to scream again. At 5:28 p.m., another staff placed crayons in her hands and asked her to color. The resident screamed and lift the table about an 1 1/2 from the floor then pushed the staff away. Interview with the Qualified Mental Retardation Professional (QMRP) on March 31, 2010, at approximately 7:00 p.m., revealed that all staff were trained on Resident #2's BSP. Review of the staff in-service training records verified revealed Resident #2's direct support staff were trained on December 1, 2009. Review of Resident #2's BSP dated December 1, 2009, on March 31, 2010, at 4:25 p.m., revealed the resident had maladaptive behaviors including self-injurious behaviors, aggressive behavior and exhibits episodes of crying and screaming. As a result, staff were required to proactively inform Resident #2 five minutes ahead of time when a change of activity or location was going to occur to prevent agitation. Additionally, the plan documented that staff should encourage the resident to "gesture pain, needs, and/or discomfort." Further review of the BSP revealed the following consequences to target behaviors: a. Verbally direct the resident to stop the behavior; b. Communicate with her to determine if she may be experiencing discomfort or otherwise; (for physical discomfort apply lotion and/or	I 222		

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I 222	Continued From page 10 moisturizer) c. After she has calmed down , she should be gradually redirected to a task that she is able to successfully do, as a means of bolstering her self-esteem and to prevent an immediate recurrence of aggression or self-injurious behaviors. At the time of the survey, there was no evidence that the GHMRP ensured each staff was effectively trained to implement strategies to manage and document Resident #2's targeted behavior of screaming.	I 222		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for two of three residents in the sample. (Residents #1 and #2) The findings include: A. The GHMRP failed to protect residents' rights by not informing the residents' medical guardians of changes in their condition and the use of	I 500		

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I 500	Continued From page 11 psychotropic medications for sedation and behavior management [Title 7, Chapter 13, § 7-1305.05(h), formerly § 6-1965(h)], as follows: 1. The GHMRP failed to ensure written informed and written consent was obtained from Resident #1's guardian prior to the administration of her psychotropic medications and the implementation of a behavior support plan as evidenced below: During the entrance conference on March 30, 2010, at approximately 10:30 a.m., the registered nurse (RN) and the qualified mental retardation professional (QMRP) indicated that Resident #1 received psychotropic medications to address her maladaptive behaviors. Further interview revealed the resident did not have the capacity to give informed consent for the use of medications and habilitation services. The statements were verified on March 30, 2010, at 6:55 p.m., through review of Resident #1's psychological assessment dated January 19, 2010. According to the assessment, Resident #1 "does not evidence the capacity to make independent decisions on her behalf or provide meaningful input into decisions regarding her habilitation planning, placement, financial, treatment, or medical matters. On March 31, 2010, at 8:55 a.m., review of the physician order dated March 1, 2010, revealed Resident #1 was prescribed Buspar for psychotropic behaviors and Risperdal for intermittent explosive disorder. At the time of the survey, the GHMRP failed to provide evidence that informed consent was obtained from the resident and/or legally authorized representative prior to the	I 500		

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I 500	Continued From page 12 administration of the psychotropic medication. 2. The GHMRP failed to ensure that informed consent was obtained from Resident #1's guardian prior to the to the implementation of her Behavior Support Plan (BSP). Interview with the RN and the QMRP on March 30, 2010, at approximately 10:30 a.m., during the entrance conference revealed that Resident #1 had a Behavior Support Plan (BSP) to address her maladaptive behaviors. Further interview revealed the resident did not have the capacity to give informed consent for the use of medications and habilitation services. The statement was verified on March 30, 2010, at 6:55 p.m., through review of Resident #1's psychological assessment dated January 19, 2010. According to the assessment, Resident #1 "does not evidence the capacity to make independent decisions on her behalf or provide meaningful input into decisions regarding her habilitation planning, placement, financial, treatment, or medical matters. Record review on March 30, 2010, at 6:55 p.m., revealed the Behavior Support Plan (BSP) dated February 2, 2010, was implemented to address her maladaptive behaviors. At the time of the survey, the GHMRP failed to provide evidence that informed consent was obtained from the resident and/or legally authorized representative prior to implementing Resident # 1's BSP. B. Chapter 13, § 7-1305.05. Visitors; mail; access to telephones; religious practice; personal possessions; privacy; exercise; diet; medical attention; medication [Formerly § 6-1965]	I 500	**1500. A 1, 2.** Informed consent for administration of Client # 1's Psychotropic Medications and implementation of her BSP have been obtained from her surrogate decision maker (Mother). In the future, the QMRP shall ensure that informed consents are signed prior to administration of Psychotropic medications and implementation of BSP.	**4/10/10**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0070	A. BUILDING _____ B. WING _____	03/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 03	1814 BUNKER HILL ROAD, NE WASHINGTON, DC 20017

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I 500	Continued From page 13 1. The GHMRP failed to ensure privacy during personal needs, for Resident #2, as evidenced below: On March 31, 2010, at 4:14 p.m., Resident #2 was observed sitting on the toilet in the bathroom with the door open. During this time, her direct support staff was observed standing in the same bathroom. Seconds later, the licensed practical nurse (LPN) was observed leaving the bathroom, however, she did not close the door completely. When interviewed on the same day at approximately 7:00 p.m., the LPN acknowledged that Resident #2 was not provided privacy while using the bathroom. At the time of the survey, there was no evidence that staff ensured privacy during Resident #2's personal care. 2. The GHMRP failed to ensure that residents had clothing that were appropriate, for Resident #1, as evidenced below: Observation conducted at Resident #1's day program on March 30, 2010, 11:41 a.m., revealed Resident #1 walking out her classroom wearing jeans that was too small. Further observation revealed the day program staff trying to pull the resident's jeans over her hips. Interview with the day program staff on March 30, 2010, at 11:45 a.m., revealed the GHMRP frequently sent Resident #1 to the day program wearing clothes that were too small. The day program reportedly had conveyed its concern to the GHMRP. Further observation on March 31, 2010, at 1:45	I 500	**1500. B 1.** Staff have been trained on issues pertaining to right, privacy, dignity and respect. The Facility's House Manager shall on a daily basis (5 days a week, Monday through Friday) ensure staff adhere to the specifications of the in-service.	**4/01/10**

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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I 500	Continued From page 14 p.m., revealed clothes stored in Resident #1's closet and dresser that were too small for her. Additional observation revealed seven out of nine supportive stockings had holes or were torn. Three out of 10 underwear were stained, and three suits hanging in her closet were also stained. Interview with the qualified mental retardation professional on March 31, 2010, at approximately 3:00 p.m., confirmed the observations of the clothing in Resident #1's dresser and closet. At the time of the survey, there was no evidence that the GHMRP ensured that Resident #1 wore appropriately fitting clothing, or that the resident's clothing were maintained in good condition.	I 500	**1500. B 2** The house manager has requested funds from client # 1's community account so as to purchase new fittings clothes. In the mean time client # 1's closet has been reorganized whereby all tight clothes and ted hose with holes have been removed.	4/29/10 4/01/10